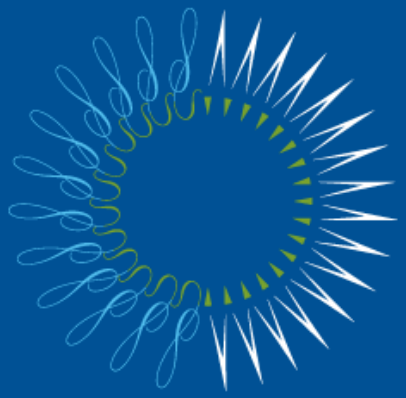


THE PEW CHARITABLE TRUSTS

Prison Health Care

Costs and Quality

Matt McKillop, Research Officer
The Pew Charitable Trusts

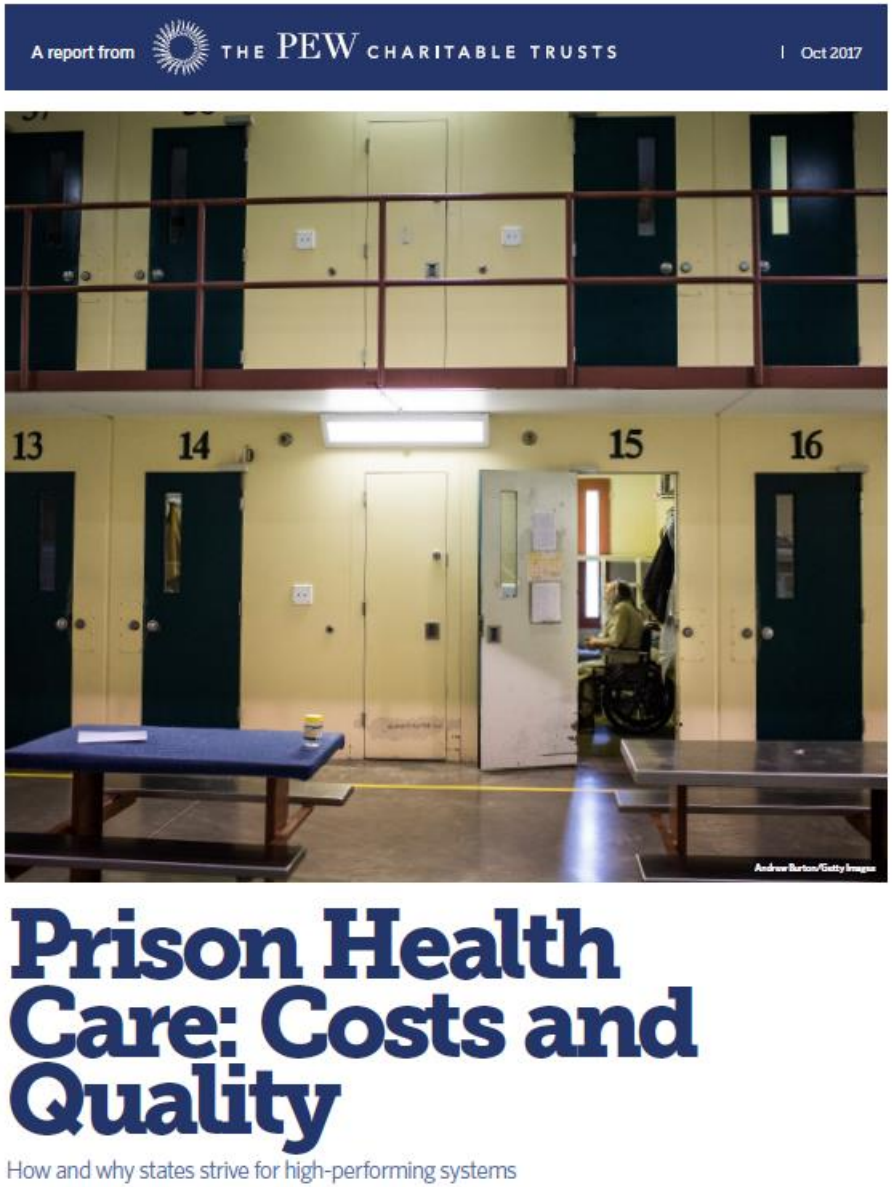
Senate Finance Committee Annual Meeting
Virginia General Assembly

Charlottesville, VA
November 16, 2017

Correctional health care research

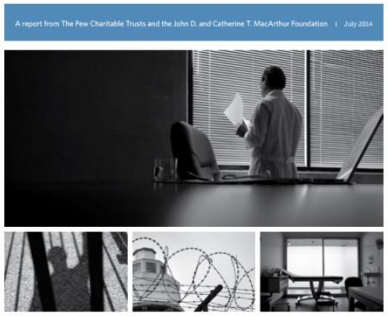
Objectives:

- Provide 50-state perspective of how health care is funded and delivered, as well as how care continuity is facilitated.
- Help decision-makers assess, improve, and preserve the value of public spending, considering costs and quality.
- Highlight policies and practices that achieve universal goals:
  - meeting constitutional obligations;
  - strengthening public health;
  - protecting public safety;
  - practicing fiscal prudence.



Key Issues

- **High stakes of prison health care.**
- **Delivery system models.**
- **Dramatic per-inmate spending variation. Why?**
  - How money is spent.
  - On whom it is spent.
  - Prices paid.
  - Accounting for quality.
- **Preserving care continuity.**



A report from The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation | July 2014

PEW | MacArthur Foundation

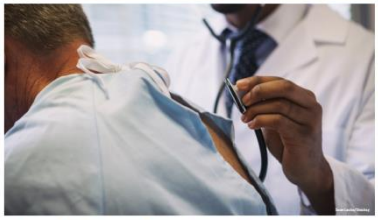
State Prison Health Care Spending

An examination

A report from THE PEW CHARITABLE TRUSTS | Oct 2017

Prison Health Care: Costs and Quality

How and why states strive for high-performing systems



A brief from THE PEW CHARITABLE TRUSTS | Dec 2015

How Medicaid Enrollment of Inmates Facilitates Health Coverage After Release

Overview

As more states and localities have begun to re-evaluate and reform their criminal justice systems in recent years, policymakers have devoted increased attention to the health care provided to individuals transitioning in and out of prisons and jails. Health care and corrections have each emerged as fiscal pressure points, and so too has the intersection of these two spheres: health care for inmates. States alone spent $7.7 billion on health care for prison inmates in fiscal year 2011.[1] Moreover, because of the extensive and, in some cases, communicable health conditions of many inmates, officials recognize that facilitating seamless access to health care upon re-entry into society improves the individuals' prospects for successful reintegration and benefits the public's health and safety. Offenders frequently enter jail or prison with a substance use disorder and/or a mental illness[2] and have high rates of chronic medical conditions (such as hypertension and diabetes) and infectious diseases (such as HIV and hepatitis C).[3] Care continuity can be especially critical with the treatment of behavioral health conditions.[4]

THE PEW CHARITABLE TRUSTS

STATELINE

Number of Older Prisoners Grows Rapidly, Threatening to Drive Up Prison Health Costs

October 07, 2015 By Matt McKillop and Frances McGaffey

Aging inmates eat lunch in the dining hall at Devens federal prison in Massachusetts on April 21, 2015.

Matt McKillop, an officer at The Pew Charitable Trusts, researches and analyzes the fiscal health of states.

A brief from THE PEW CHARITABLE TRUSTS | Aug 2016

How and When Medicaid Covers People Under Correctional Supervision

New federal guidelines clarify and revise long-standing policies

Overview

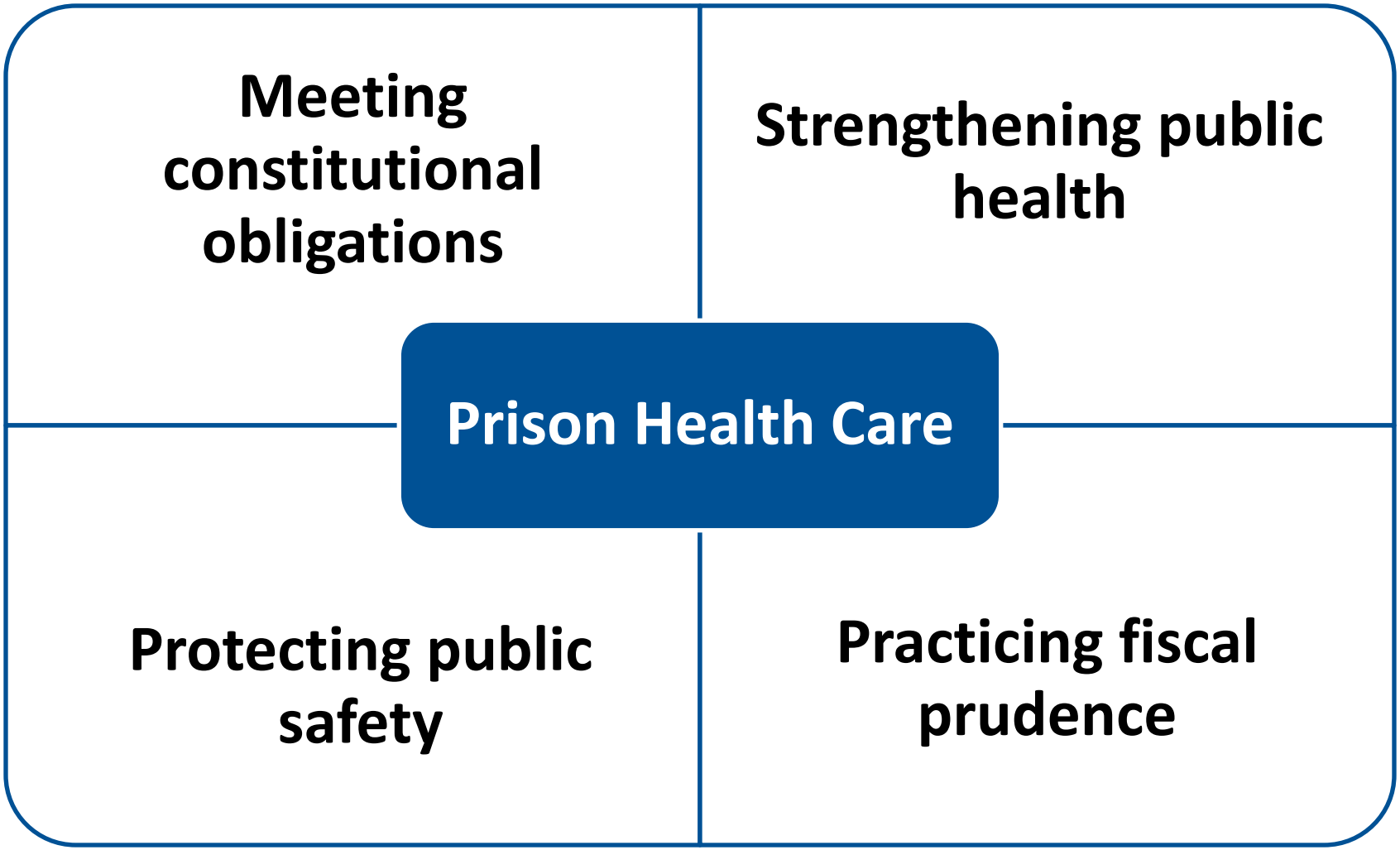
The Centers for Medicare & Medicaid Services (CMS), a unit of the U.S. Department of Health & Human Services (HHS), released new guidance in April 2016 on how states and localities may facilitate access to Medicaid coverage for individuals before, during, and after a correctional institution stay.[1] In announcing these guidelines, HHS noted that Medicaid "connects individuals to the care they need once they are in the community and can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism for justice-involved individuals,"[2] people under community supervision (e.g., parole) or incarcerated in prisons or jails. This population has disproportionately high rates of physical and behavioral health illnesses.

The guidelines reiterate and elaborate on long-standing policies pertaining to Medicaid coverage of inmates and remove some restrictions on covering certain individuals after release. This analysis, building on previous research conducted by The Pew Charitable Trusts,[3] explains CMS' latest communication, its practical impact for state and local policymaking, and how some jurisdictions have navigated this terrain.

History of Medicaid coverage for the incarcerated

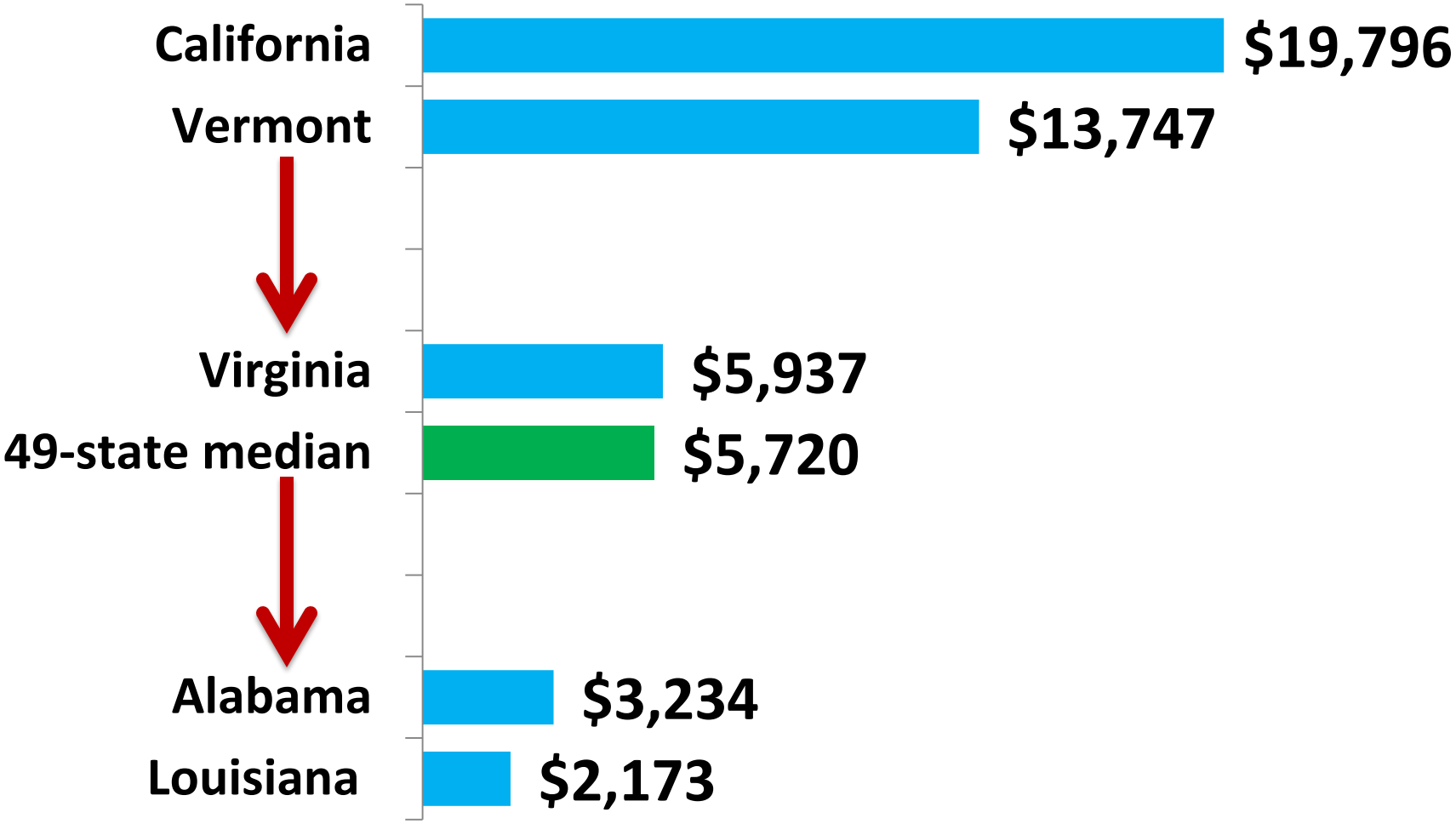
Jurisdictions have never been precluded by inmates' incarceration status from enrolling them in Medicaid, the joint federal-state health care program for vulnerable populations. CMS has long held that individuals who meet states' Medicaid eligibility criteria "may be enrolled in the program before, during, and after the

Pressing and universal state priorities



Per-inmate spending on prison health care varied greatly

FY 2015



Delivery systems, fiscal 2015

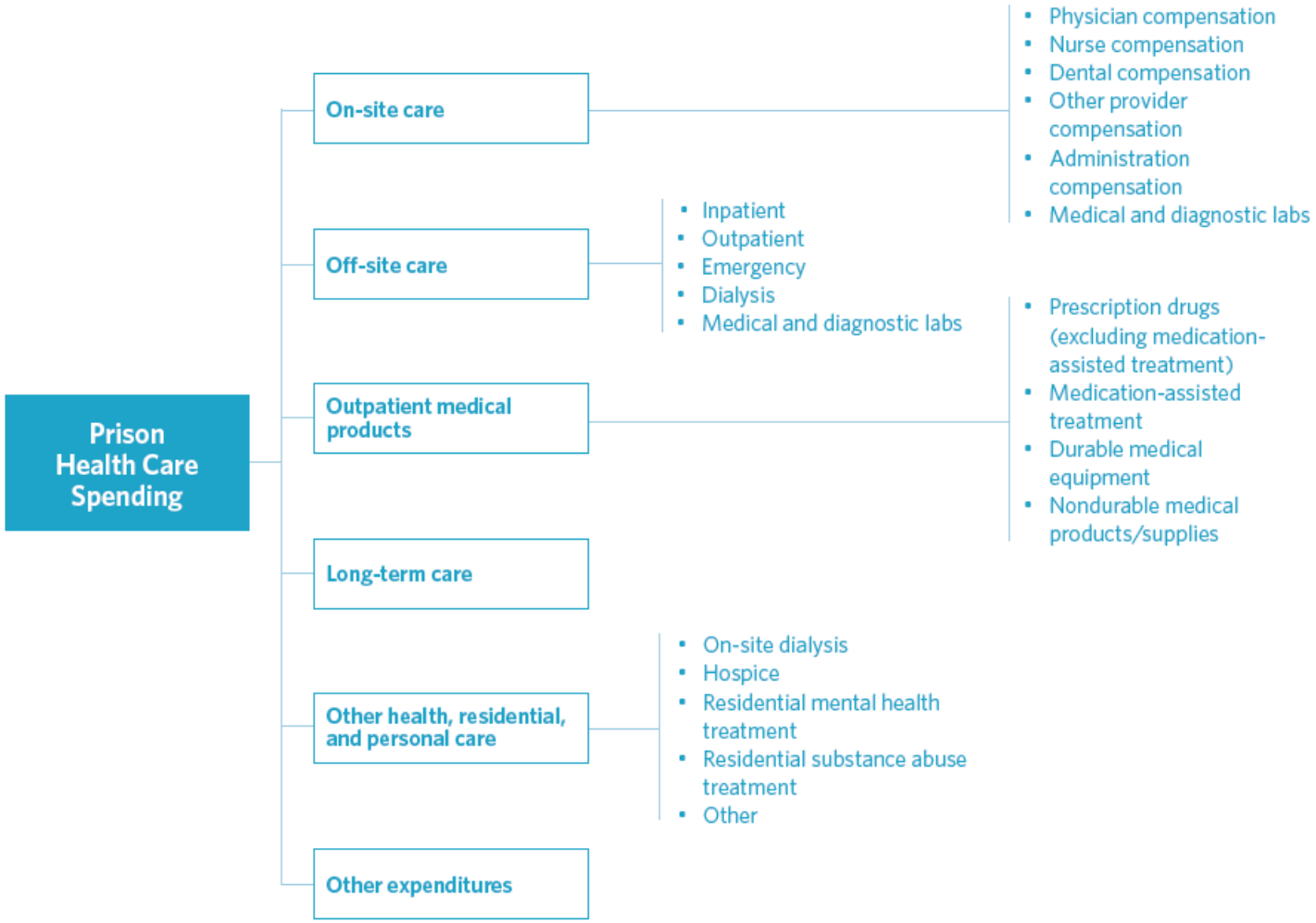
Delivery System	States	Number of States
Direct-provision	AK, CA, HI, IA, NC, ND, NE, NV, NY, OH, OK, OR, SC, SD, UT, WA, WI	17 states
Contracted-provision	AL, AZ, AR, DE, FL, ID, IL, IN, KS, KY, MA, MD, ME, MO, MS, NM, TN, VT, WV, WY	20 states
Hybrid	CO, LA, MI, MN, MT, PA, RI, VA	8 states
State university	CT, GA, NJ, TX	4 states

Note: New Hampshire did not provide data.

Off-site care: financial risk vs. decision to send

- **Who bears financial risk?**
  - VADOC, with processing by Anthem Blue Cross Blue Shield
- **Who is responsible for deciding to send an individual offsite for acute treatment?**
  - Armor or Mediko
- **Partnership with state Medicaid agency?**
  - Eligible individuals are enrolled

How states spend prison health care dollars



How VADOC spends prison health care dollars

Expenditure (nominal)	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2010-15 % Change
Personal Svcs	$27,774,117	$29,811,229	$30,191,201	$28,810,008	$26,231,301	$27,858,122	0.3%
Contractual Svcs	$102,135,820	$103,719,565	$109,977,654	$114,525,509	$110,755,396	$127,002,857	24.3%
Supplies & Mat	$16,268,136	$15,896,920	$14,719,653	$14,857,907	$13,439,979	$15,269,951	-6.1
Transfer payments	$23,749	$36,598	$9,409	$19,179	$10,610	$10,633	-55.2%
Continuous Chgs	$124,494	$112,154	$113,557	$104,438	$100,755	$89,814	-27.9%
Equipment	$95,675	$273,121	$167,466	$140,947	$406,044	$278,535	191.1%
Total	**$146,421,991**	**$149,849,587**	**$155,178,940**	**$158,457,988**	**$150,944,085**	**$170,509,912**	**16.5%**

- **VADOC's spending disaggregation may hinder a deep examination of cost drivers.**

Accounting for staffing expenditures

Per-Inmate Spending Increases With Health Staff

States with the lowest and highest health staffing levels, fiscal 2015

Bottom 10		
	FTEs per 1,000 inmates, FY 2015	Per-inmate spending, FY 2015
Oklahoma	18.6	$3,706
Illinois	19.3	$3,619
Louisiana	23.4	$2,173
Nevada	24.5	$3,246
South Carolina	25.0	$3,478
Alabama	25.3	$3,234
Indiana	25.4	$3,246
Pennsylvania	25.7	$4,548
Arizona	26.6	$3,529
Texas	27.2	$4,077
Median	**25.2**	**$3,504**

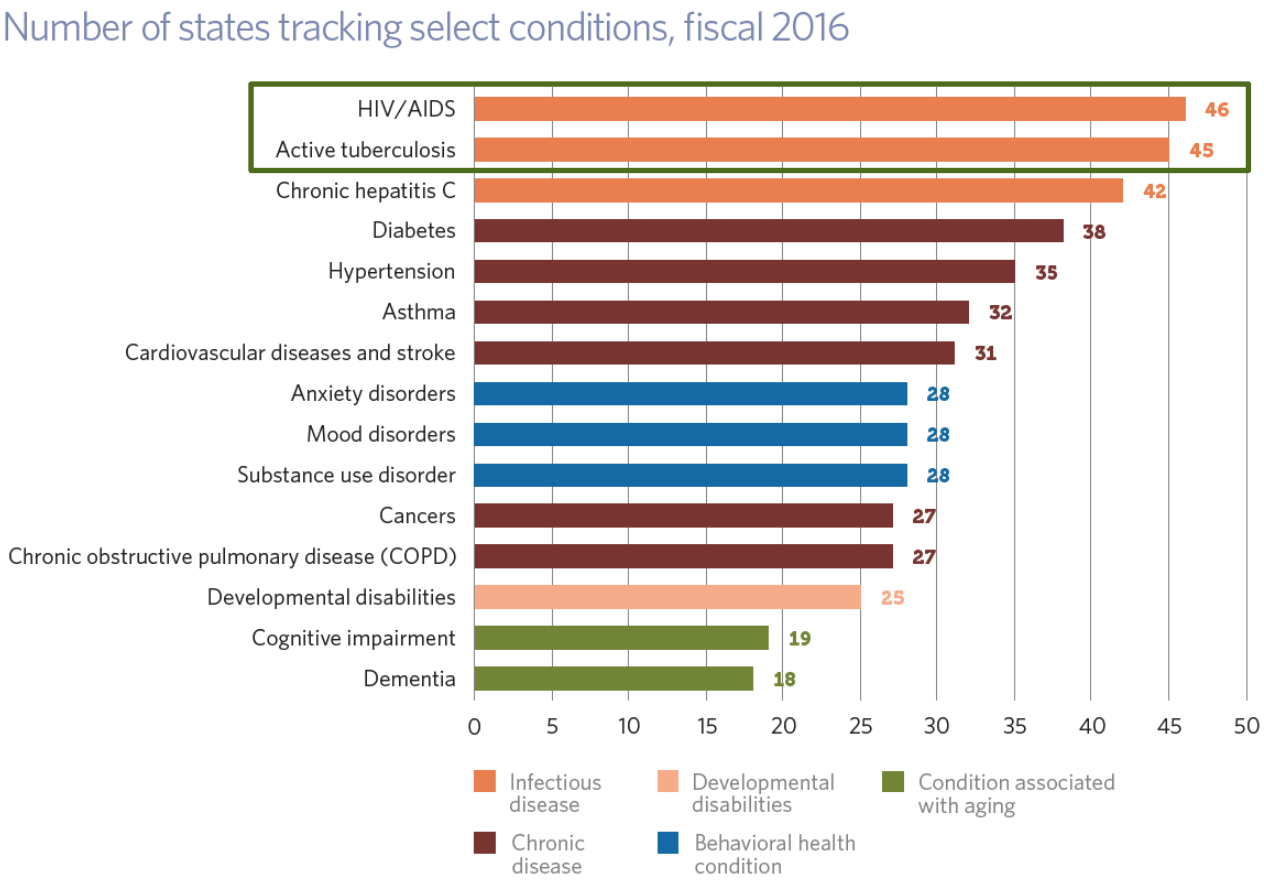
Top 10		
	FTEs per 1,000 inmates, FY 2015	Per-inmate spending, FY 2015
Maryland	54.2	$7,280
Wyoming	57.7	$11,798
Delaware	58.6	$8,408
Tennessee	58.7	$6,001
Minnesota	59.1	$8,158
Massachusetts	60.2	$8,948
California	69.9	$19,796
Hawaii	72.3	$5,422
Maine	79.3	$7,397
New Mexico	86.8	$12,293
Median	**59.6**	**$8,283**

Notes: Six states (Florida, Iowa, Rhode Island, Utah, Virginia, and Wisconsin) were excluded from this analysis because they submitted staffing data that were incomplete or not comparable.

- **Virginia was one of six states excluded from Pew's staffing level analysis because VADOC did not provide data on its number of contracted health professional FTEs, reporting that the figures were unavailable.**

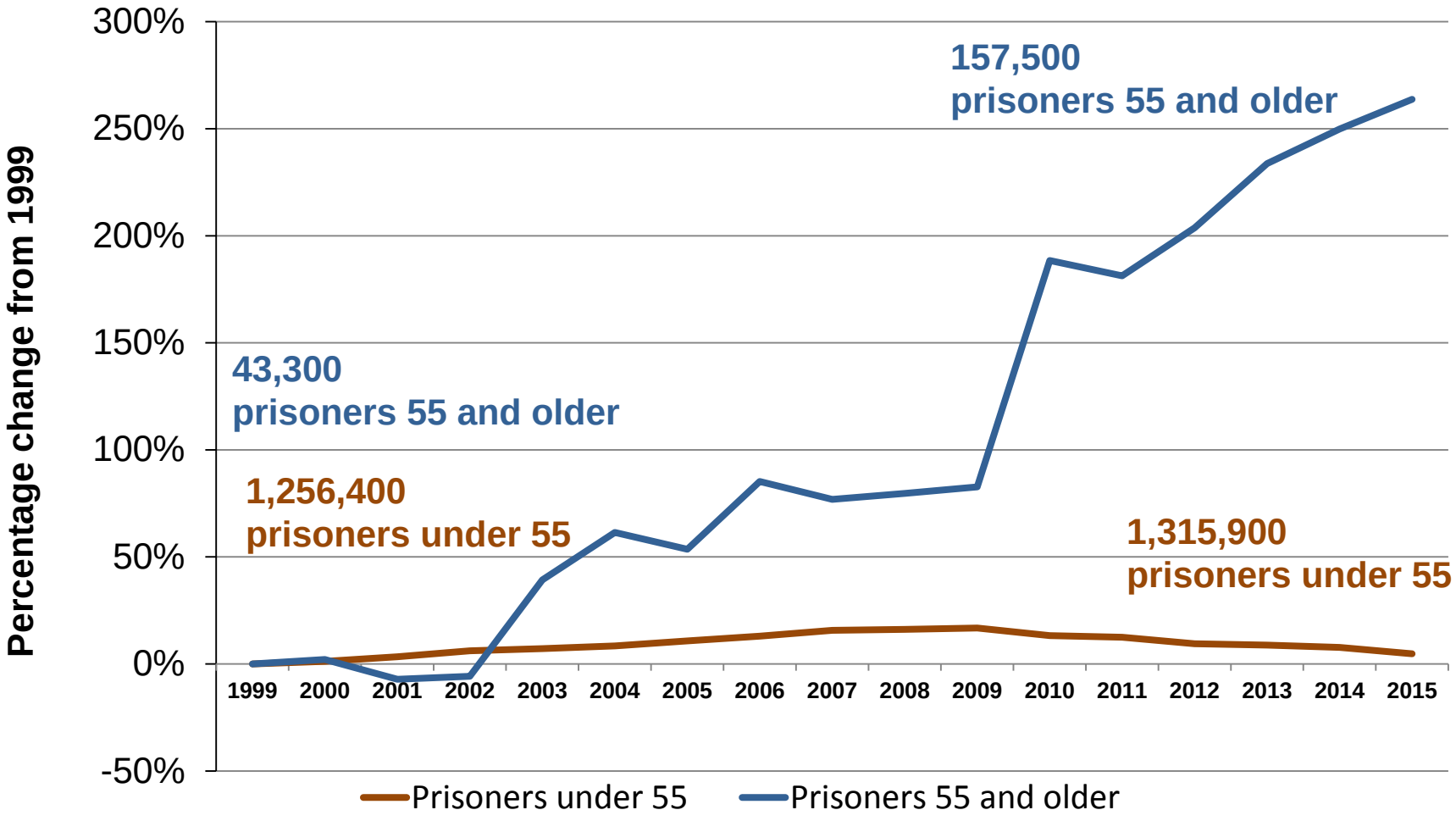
Note: New Mexico Corrections Department officials have indicated to Pew that its submitted staffing and spending figures require correction.

Whom state prison health care dollars treat



- **VADOC reported tracking the prevalence of two of 15 serious conditions common in incarcerated populations: HIV/AIDS and active tuberculosis.**

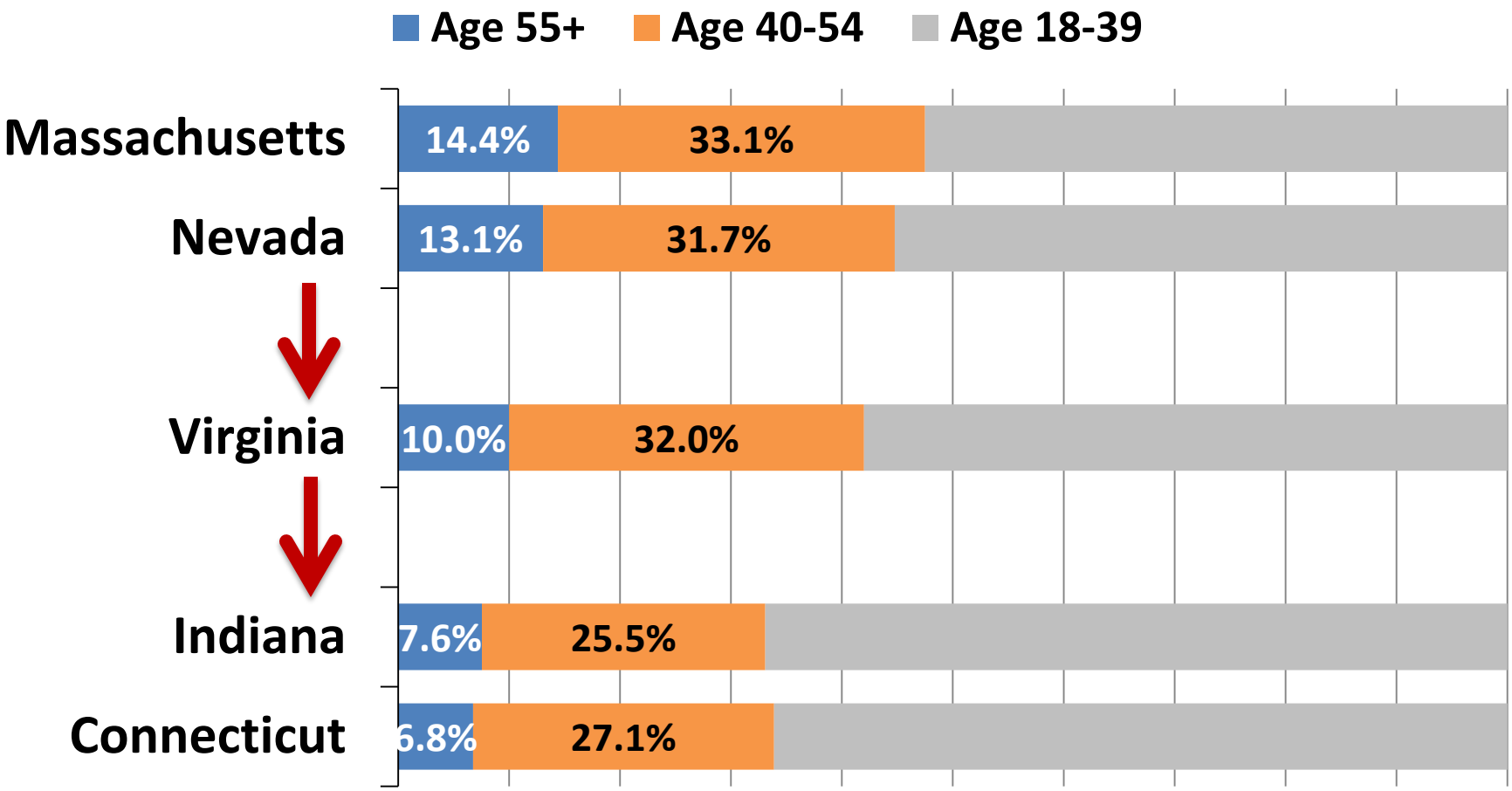
Aging prison population, 1999-2015



- **Incarcerated adults age 55 or older under VADOC's jurisdiction increased by 45 percent from fiscal 2010-15, growing from 7 percent of its population to 10 percent.**

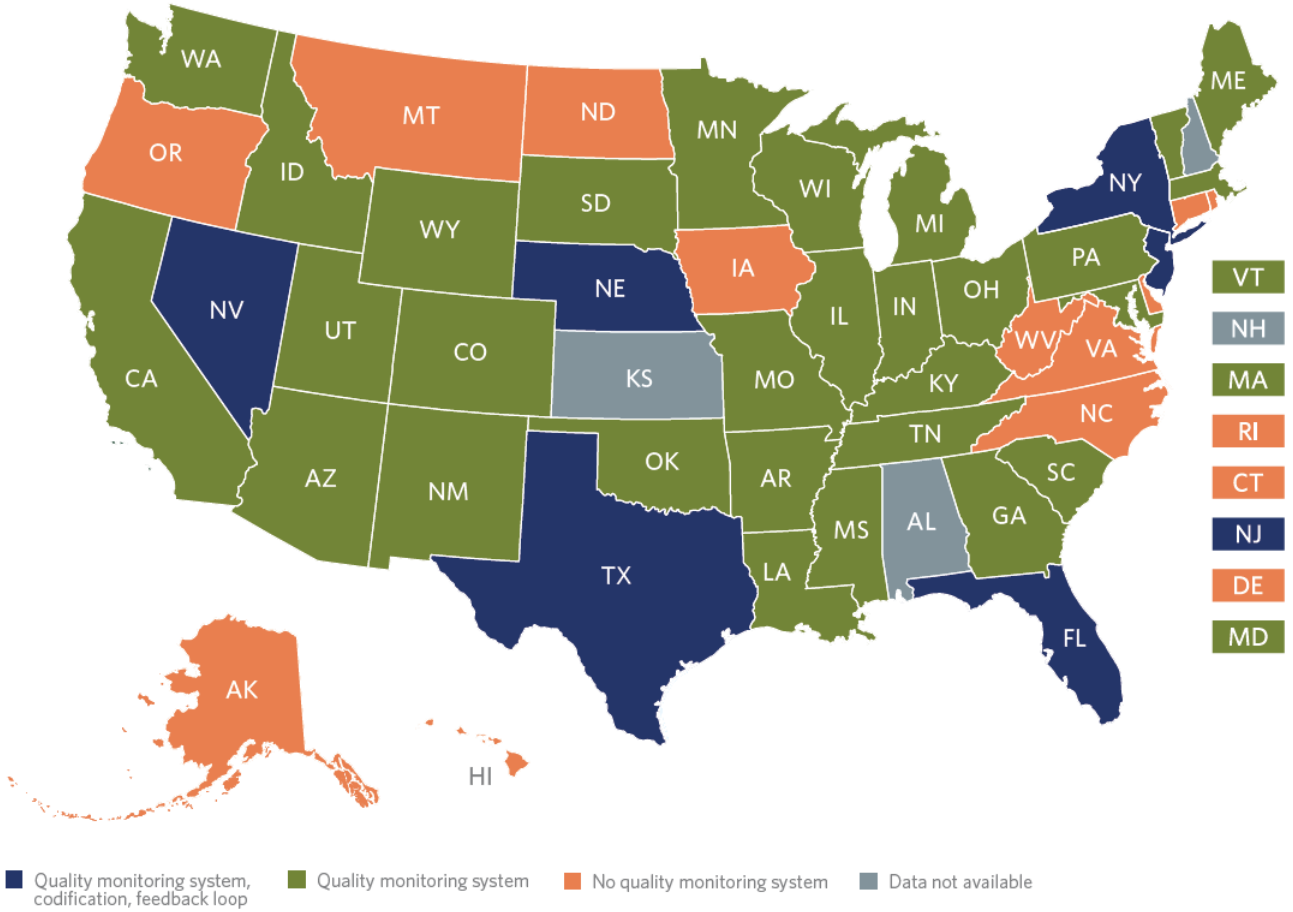
Aging state prison populations

FY 2015



Accounting for quality, FY 2016

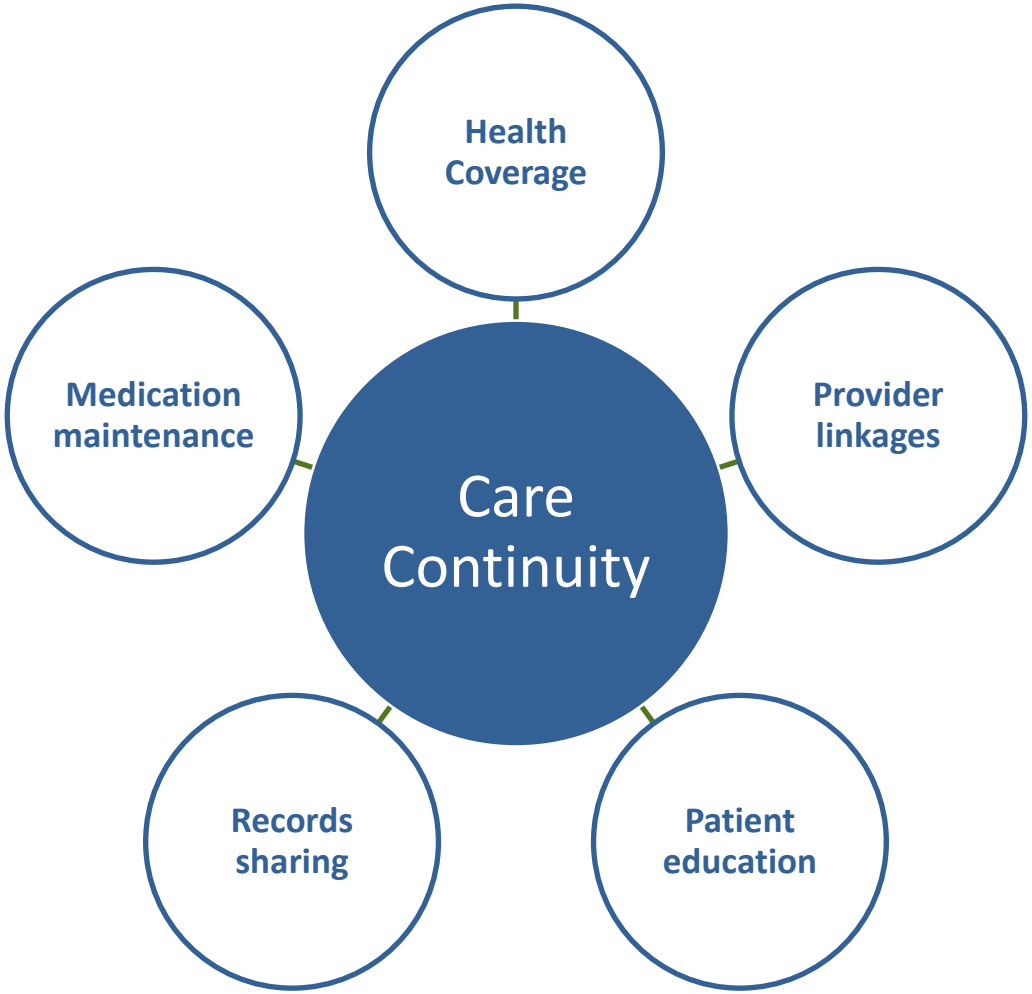
35 states have systems, six formally require and integrate them into decision-making and oversight



Electronic health records (EHR) and quality monitoring

- **Majority of prison facilities use EHR in 24 states.**
  - All interoperable between facilities.
  - Four (IN, IA, NJ, VT) interoperable with community providers.
- **Not a precondition for monitoring quality.**
- **Can facilitate care continuity.**

Protecting investments and progress through care continuity



For additional questions or information, please contact:

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